DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF10075 (07/04)

STATE OF WISCONSIN
Wis. Stats. 49.473

WISCONSIN WELL WOMAN MEDICAID DETERMINATION

Instructions:
Is the client currently enrolled in the Family Planning Waiver Program (FPW)? ☐ Yes ☐ No If you answered "No", the applicant must be enrolled in WWWP and you must attach a copy of the DPH 4818 (complete all sections, including the shaded section).
Part A – **Applicant Information** - This section needs to be completed by the applicant. Completion of this form is required to enable the Medicaid Program to authorize and pay for medical services provided to eligible recipients. Under 49.45 (4) WI Statutes, personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to the Medicaid program administration such as determining eligibility of the applicant. Failure to supply the information requested by this form may result in denial of Medicaid payment for the services.

- Enter applicant's name.
- Enter applicant's address (must be a Wisconsin address).
- Enter applicant's social security number (SSN). The provision of the SSN is required under Wisconsin Administrative code HFS 103.03 (4) for any person requesting medical services covered by the Medicaid program. The SSN and other personally identifiable information will only be used to determine eligibility for Medicaid. If the SSN is not provided benefits may be denied.
- Enter applicant's date of birth. Applicant must be 35 through 64 years of age or enrolled in the FPW Program.
- Applicant must sign and date the form.

Part B – **Referring Health Care Screener/FPW Physician** - This section of the form is to be filled out by the Wisconsin Well Woman Program screener/FPW physician.

- Enter the name of the health care provider who is attesting to the screening, diagnosis and treatment recommendation.
- Enter the date the screen was done.
- Enter the date of diagnosis. This date should be on or after the date of the screen.
- Enter the diagnosis. It may be any diagnosis of a condition of breast or cervical cancer or pre-cancerous lesions requiring treatment.
- The treatment recommended box must be checked "yes".
- The screener/physician must sign, indicating medical credential, and date the form.

Part C - Economic Support (ES) Worker can add comments as needed.

PART A - Applicant Information

Name – Last	First	MI	Social Security Number

Street Address	City	State	Zip	Birthdate (mm/dd/yy)

SIGNATURE – Applicant	Date Signed (mm/dd/yy)

PART B - Referring Health Care Screener / Physician

Name - Last	First	MI

Screener / Physician Street Address	City	State	Zip

Date of Screen	Date of Diagnosis	Treatment Recommended?
		☐ Yes ☐ No

Diagnosis
☐ Breast Cancer ☐ Pre-cancerous condition of the cervix ☐ Cancer of the cervix

Physicians Comments

SIGNATURE – Referring Health Care Screener / Physician	Date Signed (mm/dd/yy)

PART C – Agency Comments

Agency	ES Worker Only	Office Use

White - ES Yellow - Provider Pink - Local Coordinating Agency Blue - Applicant

RESET FORM